STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396009	A. BLDG: 00 B. WING:	02/11/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NORRITON SQUARE NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **068202**	**1700 PINE STREET NORRISTOWN, PA 19401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and Civil Rights Compliance survey completed on February 11, 2025 , Norriton Square, it was determined that facility was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0558 SS=E		F 0558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0558 SS=E	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	1. Resident 251 has been issued a Bariatric bed and mattress to accommodate his needs. Resident 248 heater has been replaced and is functioning 2. Maintenance Director or designee to conduct an initial audit of residents requiring a bariatric bed to ensure appropriate bed and mattress in place Maintenance Director or designee to conduct an initial audit of all resident room heaters to ensure proper functioning 3. NPE or designee to educate maintenance and nursing staff regarding identification of bariatric bed equipment needs and when resident room heaters are not functioning to notify maintenance utilizing TELS platform 4. The Maintenance Director or Designee will audit weekly 12 weeks for both PTech units and bariatric mattresses to ensure compliance. 5. NHA or designee to review the results of these audits at the monthly QAPI meeting x 3 months	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0558 SS=E	Continued from page 2 Based on observations, clinical record review, and interviews with staff and residents, it was determined that the facility failed to provide reasonable accommodations of needs relating to a bariatric bed and a functioning heater for two of 31 residents reviewed.(Residents R251 and R248) Findings include: Review of Resident R251's Minimum Data Set (MDS-federal mandated assessment for all residents) dated February 12, 2025 revealed that Resident R251 was admitted into the facility on February 6, 2025 with diagnosis' including respiratory failure (respiratory system cannot maintain normal levels of oxygen and carbon dioxide in the body), chronic congestive heart failure(long term condition , the heart is unable to pump blood effectively), type 2 diabetes(condition that occurs when blood glucose is too high) and morbid (severe) obesity (health condition that results from abnormally high body mass that is diagnoses by having a body mass index(BMI) greater then 40).	F 0558		

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F 0558 SS=E	Continued from page 3 Review Resident R251's lift transfer evaluations dated February 6, 2025, revealed Resident R251's weight dated February 6, 2025, was assessed at 316 pounds (lbs) and Resident R251's height as 65 inches. This resident is assessed of not being able to independently turn or reposition in bed or the chair, the resident requires extensive total assistance to turn reposition of two or more staff. Review of facility assessment revealed that equipment and supply inventories this facility currently has adequate equipment to supply all therapies. Medical and non-medical equipment required hospital beds with bariatric capability, and Hoyer lifts with bariatric capability. Observation of Resident 251 on February 9, 2025, at 11:05 am, revealed Resident R251 lying in a regular sized hospital bed. Maintance Director, Employee E11 fixing resident bed by releasing extender to lengthen the bed while resident was still occupying the bed. The bed was observed with	F 0558		

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F 0558 SS=E	Continued from page 4 extender and regular mattress (too small for bed frame). Interview with resident at time of observation revelaed Resident R251 vocalized discomfort. Interview with Maintance Director, Employee E11 at time of the above observations revealed that he has a new mattress to install but cannot move the resident. Employee E11 was just notified on this day that the residents bed needed adjustment. Further observation of Resident R251 on February 9, 2025, at 11:35 a.m. was observed four staff members assisting in lifting resident from bed with Hoyer lift while Maintance Director, Employee E11, extended the bed frame width and switched the mattress to accommodate for large mattress to fit bariatric bed setting. The resident bed was made to a bariatric setting three days after he was admitted into the facility.	F 0558		

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F 0558 SS=E	Continued from page 5 Observation of Resident R248 February 10, 2024, at 10:42 a.m. revealed resident sitting in chair with sheet wrapped around her. Further observation revealed cool air coming from heater unit in the resident's room. Interview with resident at time of observation revealed that resident stated she was "cold" and requested a blanket. Interview with Maintance Director, Employee E11 at time of observation revealed that the heater is "supposed to blow cool air temporality, its not broke that is how it works". This employee deferred all other questions to Regional Maintenance Director Employee E12. Interview with Regional Maintance Director, Employee E12 on February 10, 2024, at 11:05a.m. revealed that the heater unit has a safety mechanism that prevents the system form overheating and the cold air will only blow for a short time. During this	F 0558		

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F 0558 SS=E	Continued from page 6 interview Employee E12 demonstrated that the heater would turn to hot air,. Employee E12 dismantled the heater unit and determined that this unit was not functioning properly. Employee E12 confirmed that the heater unit in Residents R 248's room was not functioning. 28. Pa. Code 201.29(j) Resident rights 28. Pa. code 211.12(d)(1) Nursing services	F 0558		

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F 0558 SS=E	Continued from page 7	F 0558		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 8 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1.Physician reviewed resident R24 blood glucose levels for last 7 days with no changes to orders 2.The Director of Nursing or designee will conduct an initial audit of current residents with physician orders for blood glucose levels with parameters for the last 7 days to ensure out of range parameters are reported to the physician 3.NPE or designee will educate current licensed nurses on diabetes management and ensure physician is notified when blood glucose parameters are out of range 4. The DON or designee will conduct weekly random audits of 5 residents per week x 12 weeks of residents with accu-checks to ensure that blood sugars out of range were reported to the physician 5. DON or designee to review the results of these audits at the monthly QAPI meeting x 3 months.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0684 SS=D	Continued from page 9 Based on clinical record reviews and interviews with staff, it was determined that the facility failed to follow physician orders related to diabetes management for one of 24 residents reviewed (Resident R24). Findings include: Review of Resident R24's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated January 20, 2025, revealed that the resident was admitted to the facility on March 26, 2021, and had diagnoses including diabetes (ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose). Review of physician orders for Resident R24 revealed an order, dated May 23, 2023, to check the resident's blood glucose level and notify the physician if greater that 400.	F 0684		

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F 0684 SS=D	Continued from page 10 Review of Resident R24's blood glucose levels revealed the following: On January 24, 2025, at 4:36 p.m. blood glucose level was 416; On January 1, 2025, at 8:32 p.m. blood glucose level was 416; On December 29, 2025, at 4:18 p.m. blood glucose level was 423; On December 27, 2025, at 8:17 a.m. blood glucose level was 427; On December 25, 2025, at 8:29 a.m. blood glucose level was 427; On December 17, 2025, at 4:38 p.m. blood glucose level was 416; and On November 15, 2025, at 8:56 p.m. blood glucose level was 407. Review of medication administration records and progress notes for Resident R24 revealed that there was no indication that the physician had been notified of the above blood glucose levels. Interview on February 11, 2025, at 10:53 a.m.	F 0684		

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F 0684 SS=D	Continued from page 11 Employee E13, unit manager, confirmed the above findings. 28 Pa Code 211.12(d)(5) Nursing services	F 0684		
F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 12 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. Resident R39 and R74 had not suffered any adverse effects Resident 240 signed onto hospice services with admitting diagnosis of Failure to Thrive 2. The Director of Nursing or designee will conduct an initial audit of current residents with a physician order for weekly weights obtained as ordered and comply with the Genesis Weight policy for the last 7 days 3. NPE/IP or designee will educate current licensed nurses to ensure residents with weekly weights are obtained per physician orders and comply with the Genesis Weight policy. 4. The DON or designee will conduct weekly random audits of 5 residents per week x 12 weeks of residents with orders for weekly weights, to ensure compliance with the Genesis Weight policy 5. DON or designee to review the	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0692 SS=D	Continued from page 13	F 0692	results of these audits at the monthly QAPI meeting x 3 months.	

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F 0692 SS=D	Continued from page 14 Based on observations, staff interviews, and review of clinical records, it was determined that the facility failed to ensure that weekly weights were obtained for two out of twenty-four residents reviewed with a history of weight loss (Resident R39 and Resident R74). Findings include: Review of Resident R39's clinical record revealed that Resident R39 was admitted to the facility on September 3, 2021. Review of Resident R31's clinical record revealed the diagnoses of Huntington's Disease (neurogenerative disease), Dysarthria following Non-traumatic Sub-arachnoid Hemorrhage (cranial bleed), Dysphagia (inability/difficulty swallowing). Review of Resident R39's clinical record revealed a physician's order dated August 21, 2023 for the resident to be weight monthly every day shift starting on the 1st and ending on the 5th every month.	F 0692		

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F 0692 SS=D	Continued from page 15 Review of Resident R39's weight record revealed the following weight values in pounds (lbs.): May 1, 2024 - 150.4 lbs., June 19, 2024 - 135 lbs., July 2024 - no values recorded, August 6, 2024 - 0.0 lbs., September 19, 2024 - 135 lbs., October 30, 2024 - 112.6 lbs., November 1, 2024 - 114 lbs., December 2, 2024 - 132 lbs. (was crossed out), January 2, 2025 - 109 lbs., January 28, 2025 - 112 lbs., January 31, 2025 - 106 lbs., February 2, 2025 - 110 lbs. Further review of Resident R39's weight record revealed that on June 19, 2024, documented weight value was 0.0 pounds, Further review of Resident R39's weight record revealed a notation of "Last weight obtained - weights discontinued" next to the weight value of 0.0 pounds.	F 0692		

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F 0692 SS=D	Continued from page 16 Further review of Resident R39's weight record revealed that there was no weight for July 2024. Further review of Resident R39's weight record revealed that on August 6, 2024, Resident R39 refused to be weighed. Review of Resident R39's clinical record revealed no documented evidence that Resident R39 was reweighed or an attempt to reweigh was done. Review of Resident R39's weight record revealed that on December 2, 2024, Resident R39's weight was 132 pounds. Further review of Resident R39's weight record revealed a notation of "disputed value" next to 132 pounds. Review of Resident R39's clinical record revealed no documented evidence that Resident R39 was reweighed or an attempt to reweigh was done. Interview with Regional Nurse Employee E26 and conducted on February 11, 2025, at 12:35 pm, confirmed that there was no documented evidence that Resident R39 was reweighed in June 2024 and August 2024 after Resident R39 refused to be	F 0692		

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NORRITON SQUARE NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **068202**	**1700 PINE STREET NORRISTOWN, PA 19401**

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F 0692 SS=D	Continued from page 17 weighed on June 19, 2024, and August 6, 2024; that there was no weight for July 2024; and that Resident R39 was not reweighed after a disputed weight value in December 2, 2024. Further interview with Employee E26 revealed that if during obtaining weight for a resident, there is a significant weight difference between the weight value obtained and the previous weight value, a re-weight must be done. Further, Employee E26 also revealed that when a resident refuses to be weighed, a re-weigh must be attempted at another time and that the attempts must be documented. Review of Resident R74's clinical record revealed that Resident R74 was admitted to the facility on July 9, 2022. Review of Resident R74's care plan revealed that Resident R74 was at potential nutritional risk: history of alcohol abuse, trending weight loss with potential for further weight changes due to progressive decline expected from dementia.	F 0692		

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F 0692 SS=D	Continued from page 18 Review of Nutrition Assessment dated August 5, 2024, revealed: "Unable to assess weight changes as July weight is missing and August weight is pending". Resident R74's weight record revealed no documented evidence that Resident R74 was weight in July 2024 and May 2024 the following weight values in pounds (lbs.): October 17, 2024 - 217.2 lbs. September 4, 2024 - 216.4 lbs. July 2024 - no weight value documented June 2, 2024 - 236 lbs. May 2024 - no weight value documented April 2, 2024 - 235.2 lbs. Interview with Regional Nurse Employee E26 and conducted on February 11, 2025, at 12:35 pm, confirmed that there was no weight for Resident R74 for July 2024 and May 2024. Review of resident R240's Minimum Data Set	F 0692		

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F 0692 SS=D	Continued from page 19 (MDS a federal mandated assessment for all residents) dated February 1, 2025 revealed resident R 240 was admitted June 8, 2022 with diagnosis' including metabolic encephalopathy (brain dysfunction caused by metabolic imbalance), diabetes (metabolic disease characterized by elevated levels of blood glucose) unspecified protein calorie malnutrition, and spinal stenosis and dysphagia (difficulty swallowing). Review of resident's weights dated August 12, 2024 through present date February 7, 2025 revealed a steady decline of weight totaling a weight loss of 57.8 lbs in six month time. August 12, 2024, resident weight 237 .8lbs. August 21, 2024, resident weight 234.2lbs. a 1.51% weight loss September 19, 2024, resident weight 227.6 lbs. a 2.82% weight loss. October 26, 2024, resident weight 221.8 lbs. a 2.61% weight loss. October 31, 2024, resident weight 215.7 lbs. a	F 0692		

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F 0692 SS=D	Continued from page 20 2.75% weight loss. November 1, 2024, resident weight 214.8 lbs. a 42% weight loss. December 30, 2024, resident weight 210.4 lbs. a 2.05% weight loss. January 21, 2025, resident weight 196.6 lbs. a 5.41% weight loss. January 23, 2025 resident weight 193 lbs. a 3.31% weight loss and a 18.84% weight loss over 6 months. February 3, 2025 resident weight 180. lbs. a 7.22% weight loss. Review of residents clinical record revealed that during the month of August 2024 to February 2025 this resident was hospitalized on the following dates: October 19, 2024 through October 23, 2024 October 23, 2024 through October 25, 2024 December 4, 2024 through December 11, 2024 January 16, 2025 through January 21, 2025 Comparison time and weight loss revealed that in the months of August 2024 through September	F 0692		

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F 0692 SS=D	Continued from page 21 2024 Resident R240 had a weight loss of 6.6 lbs. prior to hospitalization. Continued comparison revealed that from October 26, 2024 through November 1, 2025 the resident had a 7 lb weight loss after returning from the hospital and again from January 21, 2025 through January 23, 2025 a 3.6 lb weight loss. Review of physician orders dated February 1, 2025 revealed an order for the resident to be weighed every day shift for four weeks. There is no documentation that weights were obtained as ordered by the physician. Further review of physician orders revelaed an order for house supplement dated February 7, 2025 and an order to offer evening snacks also dated Febraury 7, 2025. Review of Resident R240's clinical record revealed multiple nutritional assessments from the time of August 2024 to through February 7, 2025 that revealed Resident R240 was assessed as eating a	F 0692		

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F 0692 SS=D	Continued from page 22 regular diet double portion most of his meals, appears well nourished, weight loss detected likely due to hospitalizations. Review of Nutritional assessment dated the January 22, 2025 revealed "residents weight 196.6 BMI (body mass index) 29 weight loss of 13 pounds * 1 month 25.2 pounds times three months weight loss likely related to recent hospitalizations plan is to encourage PO intakes continue to encourage dietary compliance desirable due to obesity RD (Registered Dietician) will continue to monitor weight intakes labs meds and skin as well as update CP (care plan)." Review of resident's care plan revealed resident is it nutritional risk related to trending significant weight loss since October of 2024 multiple recent hospitalizations history of obese BMI created on February 7, 2025 with implement interventions offer HS (evening) snack and house supplement once daily.	F 0692		

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F 0692 SS=D	Continued from page 23 Review of Registered Dietitian's note dated February 7, 2025 revealed weight change significant weight loss of 58 pounds over six months weight loss related to multiple recent hospitalizations order for meal monitoring times three days recommending adding health supplement every day continue double portions and snack goal is for weight stability without further losses Physician note day of February 4, 2025 "resident is seen for new admission post hospitalization only notation indicated in this note is denies weight loss fever and chills". Interview with interim Registered Dietician, Employee E5 on February 10, 2025 at 11:00 a.m. revealed that the resident was assessed for significant weight loss but due to frequent hospitalizations. This employee could not determine why the resident continued to lose weight while in the facility post hospitalizations.	F 0692		

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F 0692 SS=D	Continued from page 24 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12(d)(1)(3) Nursing services	F 0692		
F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Resident R17 and R56 had not suffered any adverse reactions and oxygen tubing was changed/dated 2. The Director of Nursing or designee will complete an initial audit of all residents receiving oxygen therapy to ensure oxygen tubing changed per Physician order for the last 7 days 3. NPE/IP or designee will re-educate licensed nurses on Oxygen Therapy Management to ensure oxygen tubing changed per physician order 4. DON or designee will conduct weekly audits x 12 weeks on 5 random residents to ensure Oxygen tubing was changed per physician order to ensure compliance 5. DON or designee to review the results of these audits at the monthly QAPI meeting x 3 months	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0695 SS=D	Continued from page 25 Based on observation, review of facility policy and interviews with staff, it was determined that the facility did not maintain respiratory equipment according to professional standards of practice for two of twenty-four residents reviewed. (Resident R17 and Resident R56) Findings: Review of facility policy entitled "Oxygen: Concentrator" revealed that An Oxygen concentrator extracts oxygen molecules from room air. It can be used for low oxygen flows rates (i.e. 1-4 L/min). #9. Label, date, and attach pre-filled humidifier bottle, if applicable. Review of Resident R17's clinical record revealed that Resident R17 was admitted to the facility on February 25, 2022, with most recent readmission of February 2, 2025. Further review of Resident R17's clinical record revealed the following diagnoses Chronic Diastolic	F 0695		

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F 0695 SS=D	Continued from page 26 Congestive Heart Failure (excessive body fluid caused by a weakened heart muscle) and Atrial Fibrillation (irregular and rapid heart beat). Review of Resident R17's physician's orders revealed an order for: Oxygen at 2 L/min via Nasal Cannula, continuously. every shift Post Tx: Evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds-dated February 5, 2025. Observation conducted during tour of the 3rd floor unit on February 9, 2024, at 10:30 am revealed that Resident R17 was in bed sleeping. Further observation revealed that Resident R17 was on Oxygen concentrator at 3 liters/minute via nasal cannula. Further observation revealed that the Oxygen tubing did not have a date affixed to it. Interview with licensed nurse Employee E3 conducted at the time of the observation confirmed that Resident R17's oxygen tubing was not dated. Further, Employee E3 revealed that oxygen tubings are changed once a week.	F 0695		

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F 0695 SS=D	Continued from page 27 Review of resident R56's clinical record revealed that Resident R56 was admitted to the facility on November 29, 2019. Further review if Resident R56's clinical record revealed that Resident R56 had diagnoses of Chronic Obstructive Pulmonary Disease (disease process that causes decreased ability of the lungs to perform), Chronic respiratory failure . Review of Resident R56's physician's order revealed an order obtained January 7, 2025 for: Oxygen tubing to be changed weekly. Oxygen at 6 L/min via Nasal Cannula, continuously every shift Post T x: Evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds. -ordered 10.22.24 Review of Resident R56's quarterly MDS (minimum data set- a federally required resident assessment conducted at a specific interval) dated November 8, 2024, section O 0110. Special Treatments, Procedures, and Programs,	F 0695		

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F 0695 SS=D	Continued from page 28 C1 Oxygen therapy, was coded "yes". Observation conducted during tour if the 3rd floor unit on February 9, 2024, at 10:37 am revealed that Resident R56 was in bed sleeping with oxygen concentrator at 6 liters/minute via nasal cannula. Further observation revealed that the humidifier bottle and the oxygen tubing were not dated. Interview with licensed nurse Employee E3 conducted at the time of the observation revealed that oxygen tubings are changed once a week. Further Employee E3 confirmed that Resident R56's humidifier bottle and oxygen tubing were not dated. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0695		

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F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 30 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. No resident was adversely impacted due to unsecured medications in an unattended, unlocked medication cart. Employee E7 and E23 were re-educated by NPE on Medication Cart Safety/Management to ensure medications are secured and not left unattended on top of the med cart and med carts are locked while unattended. 2. NPE or designee to conduct an initial house audit to ensure all medication carts are locked and free from unsecured medications. 3. NPE or designee will re-educate all licensed nurses on Medication Cart Safety/Management to ensure medications are secured and not left unattended on top of the med cart and med carts are locked while unattended. 4. DON or designee will conduct 5 random weekly audits x 12 weeks to ensure medications are secured and	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0761 SS=D	Continued from page 31	F 0761	not left unattended on top of the med cart and med carts are locked while unattended. 5. DON or designee to review the results of these audits at the monthly QAPI meeting x 3 months.	

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F 0761 SS=D	Continued from page 32 Based on observation, review of facility policies and interview with staff, it was determined that the facility failed to ensure that a medication cart was kept locked when not in use and that medications were properly stored for two of two carts. (Medication Cart A and Medication Cart B) Findings include: Review of facility documentation titled "Medication Storage" dated January 2025 revealed that medication storage and biologicals are stored properly to support safe effective drug administration. The pharmacy dispenses medication that meets state and federal labeling requirements, medications are to remain in containers and stored in a controlled environment this may include such containers as medication carts, medication rooms, and medication cabinets. Licensed nurses, pharmacy staff and those lawfully authorized to medications are to have access the medication carts. Medication should remain locked with not in the use or attended to by persons with authorized access.	F 0761		

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F 0761 SS=D	Continued from page 33 The medication supply shall be accessible only to licensed nursing personnel pharmacy personnel or staff members lawfully authorized to administer medication. Observation of medication cart A located in the hall of the second floor on February 9, 2025, at 8:35 a.m. revealed a bottle of over-the-counter medication aspirin set on the top of the cart. The medication cart A was unlocked and unsupervised. Interview with licensed nurse, Employee E7 on February 9, 2025, at 8:39a.m., this employee confirmed that cart was her responsibility, and she left the cart to assist a resident. Observation of medication cart B on February 9, 2025, at 08:49 am during medication pass with licensed nurse, Employee E23 the cart was viewed to have an over-the-counter medication bottle of mucus relief expectorant being used to support the medication cart computer.	F 0761		

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F 0761 SS=D	Continued from page 34 Interview with Employee E23 at time of observation confirmed that the medication bottle was not an appropriate use to secure the computer. 28 Pa. Code 211.9(a)(1) Pharmacy Services 28 Pa. Code 211.12(d)(5) Nursing Services	F 0761		

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F 0761 SS=D	Continued from page 35	F 0761		
F 0806 SS=D		F 0806		

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F 0806 SS=D	Continued from page 36 483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 0806	1. Resident R43 was provided with the appropriate diet for lunch Resident R42 was provided with the appropriate diet for lunch Resident R19 was provided with the appropriate diet for lunch 2. Food Service Director or designee to complete an initial audit of all residents with food preferences and substitutes to ensure compliance 3. Food Service Director or designee to re-educate all kitchen staff to ensure residents are receiving the appropriate diet and food preferences NPE or designee to educate all nursing staff on verifying meal ticket with food tray prior to delivery 4. Food Service Director or designee to conduct 5 random weekly audits to ensure appropriate diet and food preferences are accurate.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0806 SS=D	Continued from page 37	F 0806	5. Director of Dietary or Designee to review findings monthly during the Quality Improvement Committee x 3 months.	

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F 0806 SS=D	Continued from page 38 Based on observations and interviews with residents and staff, it was determined that the facility did not provide foods in accordance with resident preferences for three of 24 residents reviewed (Residents R43, R42 and R19). Findings include: Review of resident R 43's quarterly minimum data set (MDS- a federal mandated assessment of all residents) December 24, 2025, revealed resident r 43 was admitted into the facility August 14, 202 with diagnosis' including coronary artery disease(CAD-Plaque buildup in the hearts arteries), heart failure, anxiety(disorder of episodes of intense anxiety and fear), schizophrenia(mental disorder characterized hallucinations, delusions and disorganized thinking and behavior). Resident 43 requires setup and cleanup assistance for dining. Review of resident R43's physician orders dated October 23, 2024, revealed an order for lacto- ovo vegetarian diet (a diet that excludes meat, poultry,	F 0806		

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F 0806 SS=D	Continued from page 39 and fish, but allows eggs and dairy products) Review of resident R 43 care plan revealed that resident R 43 is at nutritional risk related to underweight bmi(body mass index-calculated measure of weight relative to height) and has potential for weight fluctuations. Resident R43 is now in hospice therefore has potential for weight loss but focuses comfort care date revised on December 24th, 2024, with interventions including to honor food preferences within meal plan vegetarian, eggs, dairy, and fish. Observation of resident R 43 receiving the lunch tray on February 9, 2025, at 12:25 p.m. revealed that resident R 43 lunch order was to be a vegetarian burger, basil roasted carrots, and seasoned potatoes wedges. The lunch tray delivered to resident 43, consisted of a fish sandwich with a side of mashed potatoes. The above observation was confirmed by medical supply coordinator employee E 22. This employee notified the kitchen of the mistake and ordered the correct lunch.	F 0806		

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F 0806 SS=D	Continued from page 40 Interview with dietary employee, E5 on February 10, 2024, at 11:35a.m. confirmed the order for resident R 43 was incorrect and was resolved immediately. Interview on February 9, 2025, at 12:49 p.m. revealed Resident R42's family member stated that the resident follows a vegetarian diet and that the facility does not always provide vegetarian foods as requested. Review of Resident R42's care plan, dated April 12, 2019, revealed that the resident was at nutritional risk with interventions including maintain the resident's cultural food preferences, provide vegetarian diet and to honor the resident's food preferences. Observation on February 9, 2025, at 12:56 p.m. of Resident R42's meal slip revealed that the resident was supposed to receive a vegetarian burger patty, cottage cheese and a vegetable and cheese sandwich on whole wheat bread. Observation of the	F 0806		

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F 0806 SS=D	Continued from page 41 resident's meal revealed that the resident did not receive any of the above items. Interview on January 9, 2025, at 1:22 p.m. Employee E4, nurse aide, confirmed that the resident did not receive the requested items on his lunch tray. Employee E4, nurse aide, stated that residents often complain that they do not receive menu items as requested. Review of Resident R19's care plan, dated October 4, 2023, revealed that the resident was at nutritional risk, with interventions including maintain the resident's cultural food preferences, provide vegetarian diet and to honor the resident's food preferences. Observation on February 9, 2025, at 1:13 p.m. revealed that Resident R19 received potatoes, carrots, cake and juice for lunch. Review of Resident R19's meal slip revealed that the resident was supposed to receive a vegetarian burger patty with her meal. Interview with Resident R19	F 0806		

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F 0806 SS=D	Continued from page 42 confirmed that she did not receive a vegetarian burger patty or any source of protein with her meal. Resident R19 stated that she prefers either the vegetarian burger patty or cheese with her meals. Interview on February 10, 2025, at 12:52 p.m. Employee E6, food service director, revealed that veggie burger patties and cheese were available in the kitchen to serve with meals. Employee E6, food service director, was unable to explain why these items were not served to Residents R42 and R19 and stated that maybe the weekend kitchen staff were not aware of the residents' food preferences. 28 Pa Code 211.6(a) Dietary services 28 Pa Code 211.10(c) Resident care policies	F 0806		

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F 0812 SS=D	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. All food items not labeled or dated were removed and discarded. 2.Food Service Manager to conduct an initial audit to ensure all food is stored, labeled and dated as per regulations. 3. Food Service Manager or designee to re-educate dietary staff to ensure food is stored, labeled and dated as per policy. 4. Food Service Manager or Designee to complete random weekly audits X 12 to ensure food is labeled, stored and dated 5. NHA or Designee to review findings monthly during the Quality Improvement Committee x 3 months.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0812 SS=D	Continued from page 44 Based on observations, interviews with staff, and a review of facility procedures, it was determined that the facility failed to store food, in accordance with professional standards for food service safety. Findings include: Review of facility Policy entitled "Receiving" revealed that under "Policy Statement": Safe food handling procedures for time and temperature control will be practiced in transportation, delivery and subsequent storage of all food items. Under section "Procedures": #5. All food items will be appropriately labelled and dated either through manufacturer packaging or staff notation. #7. All non-perishable foods and supplies will be stored appropriately Observation of the general kitchen area during the tour of the kitchen conducted on February 9, 2025, at 8:59 am revealed two metal shelving units against the wall of the kitchen.	F 0812		

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F 0812 SS=D	Continued from page 45 Observation of one of the shelving units revealed that the middle shelf of the metal shelving unit had a plastic bin with white powder. Further, the plastic bin was labelled "breadcrumbs" with label indicating "opened 12/19/24" and "use by 1.19.25". Interview with dietary staff Employee E29 conducted at the time of the observation revealed that the white powder in the bin labelled breadcrumbs was corn starch and not breadcrumbs. Further observation revealed another plastic bin of white fine grainy white substance was next to the bin labelled "breadcrumbs". Further, the bin containing the white fine grainy substance was not labelled. Interview with dietary staff Employee E29 conducted at the time of the observation revealed that the white fine grainy substance in the unlabeled plastic bin was white sugar. Further observation revealed that the bottom shelf of the metal shelving unit revealed another plastic bin	F 0812		

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F 0812 SS=D	Continued from page 46 containing a white powder. Further the bin containing the white powder was not labeled. Interview with dietary staff Employee E29 conducted at the time of the observation revealed that the white powder in the unlabeled bin at the bottom of the shelf was flour. Observation of the bottom shelf of the second metal shelving unit revealed a plastic bin containing a yellowish course grainy substance. Further the bin containing the yellowish course grainy substance was not labeled. Interview with dietary staff conducted at the time of the observation revealed that the yellowish course grainy substance in the unlabeled bin was panko. Observation of the freezer revealed a metal pan containing mixed pasta covered in saran wrap. Further, the metal pan was not labelled. Observation during refrigerator inspection revealed	F 0812		

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F 0812 SS=D	Continued from page 47 ten sandwiches wrapped in saran wrap. Further observation revealed that the sandwiched were not labelled. Further observation revealed one loaf of bread in a plastic bag. Further, the loaf of bread was not labelled. Further observation revealed three plates of salad (green leafy vegetables) with a slice ham. Further observation revealed that the three plates of salad (green leafy vegetables) with ham were not labelled. Observation of the dry storage room revealed a plastic bin with cover half filled with cereal. Further observation revealed that the plastic bin containing cereal was not labelled. Further observation revealed uncooked spaghetti wrapped in saran wrap. Further observation revealed that the uncooked spaghetti wrapped in saran wrap was not labelled.	F 0812		

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F 0812 SS=D	Continued from page 48 Further observation revealed an opened plastic bag of uncooked fettuccini wrapped in saran wrap. Further observation revealed that the opened plastic of uncooked fettuccini wrapped in saran wrap was not labelled. Further observation revealed an opened bag of rice crispies without the box, with the plastic wide open with rice crispies exposed to air. Further observation revealed that the opened bag of rice crispies was not labelled. Further observation revealed an opened bag of cornflakes without the box, with the plastic wide open with cornflakes exposed to air. Further observation revealed that the opened bag of corn flakes was not labelled. Follow-up tour of the kitchen with District Manager Employee E27 and kitchen supervisor Employee E28 conducted on February 9, 2025, at 10:20 am confirmed the above observations	F 0812		

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F 0812 SS=D	Continued from page 49 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management	F 0812		
F 0839 SS=D	483.70(e)(1)(2) Staff Qualifications §483.70(e) Staff qualifications. §483.70(e)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(e)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by:	F 0839	1. Employee E21 provided no direct care and caused no harm to residents. Employee E 17 and E 16 are no longer employed at the facility 2. Employee E21 was educated on his responsibility to ensure his license is renewed timely and active. 3. NPE or designee to educate licensed nursing staff on the importance of timely license renewal 4. NPE or designee will conduct an initial audit of licensed nursing staff then monthly audits x 3 months to ensure compliance 5. NHA or designee to review results of these audits at the monthly QAPI meeting x 3 months	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0839 SS=D	Continued from page 50 Based on observations, review of facility documentation, review of personnel files and interviews with staff, it was determined that the facility failed to ensure that staff were licensed and registered in accordance with State laws for three of 11 personnel files reviewed (Employees E21, E17 and E16). Findings include: Review of facility documentation submitted to the Pennsylvania Department of Health on December 20, 2024, at 4:33 p.m. revealed that on December 18, 2024, the facility discovered that Employee E21, RN (registered nurse), was working with an expired nursing license and that the license had expired on October 31, 2024. The facility provided education to Employee E21, RN, including its policy that it is the responsibility of the employee to maintain an active nursing license at all times and that if the license is not current that the employee may not work until the license is active. Employee E21, RN, subsequently reactivated her nursing license on	F 0839		

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	396009	A. BLDG: 00 B. WING:	02/11/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NORRITON SQUARE NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **068202**	**1700 PINE STREET NORRISTOWN, PA 19401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0839 SS=D	Continued from page 51 December 20, 2024. In response to the above incident, that facility conducted an audit of all employees with nursing licenses and nurse aide registries. Review of the audit revealed that Employees E17 and E16, nurse aides, were not included on the audit. Review of Employee E17's personnel file revealed that the employee was hired on October 22, 2024, as a nurse aide. Continued review revealed that the employee completed a nurse aide training course on October 10, 2024. Review of Employee E16's personnel file revealed that the employee was hired on November 19, 2024, as a nurse aide. Continued review revealed that the employee completed a nurse aide training course on September 20, 2024. Observation on February 9, 2025, revealed that Employee E16, nurse aide, provided care to residents on the second floor nursing unit during the	F 0839		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0839 SS=D	Continued from page 52 day shift. Review of the Pennsylvania Department of Health requirements for nurse aides, published at https://www.pa.gov/agencies/health/business-registration-and-regulation/nurse-aide.html, revealed, "A nurse aide who is not enrolled or in good standing on the registry may not be employed in a nursing care facility that receives Medicare or Medicaid reimbursement." Review of the Pennsylvania nurse aide registry on February 10, 2025, revealed that Employees E17 and E16 were not enrolled on the registry. Interview on February 10, 2025, at 1:37 p.m. the Nursing Home Administrator confirmed that Employee E21, RN, worked with an expired nursing license in November and December 2024. Continued interview revealed that Employees E17 and E16 were not identified during the facility's audit of licensed and registered nursing staff because the employees were not registered to work as nurse	F 0839		

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F 0839 SS=D	Continued from page 53 aides in Pennsylvania. 28 Pa Code 201.3 Definitions - Nurse aide (iv) 28 Pa Code 201.3 Definitions - RN registered nurse 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.19(3) Personnel policies and procedures 28 Pa Code 211.12(d)(1) Nursing services	F 0839		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 54 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1.Resident R35 was placed on Enhanced Barrier Precautions 2.IP or designee to conduct initial house audit to ensure all residents are identified for enhanced barrier precautions. 3. Infection Preventionist or designee will educate all staff on Enhanced Barrier Precautions 4. Infection Preventionist or designee will conduct 5 random weekly audits x 12 weeks to ensure staff are compliant with EBP 5. DON or designee to review the results of these audits at the monthly QAPI meeting x 3 months	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 55 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 56	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 57 Based upon observation, interviews and review of clinical records and facility policy, it was determined the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of multi-drug resistant organism (MDRO) transmission for one of 31 residents reviewed. (Resident R35) Findings include: Review of facility policy titled "Enhanced Barrier Precautions" revised December 16, 2024, revealed enhanced barrier precautions (EBP) are an infection control intervention designed to reduce the transmission of novel or multidrug resistant organisms. It employs targeted personal protective equipment (PPE) during high contact resident activities. This includes all residents with any other following infection or colonization with targeted MDRO, chronic wounds, indwelling medical devices (eg:	F 0880		

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F 0880 SS=D	Continued from page 58 central line, urinary catheter, feeding tube, tracheotomy). The use of personal protective equipment (PPE) must be used during high contact patient care activities include dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and device care. Personal protective equipment should be accessible and located outside the patient's room. Appropriate enhanced barrier precautions (EBP) sign on patient's room door. All staff receive training on enhanced barrier precaution upon higher and as needed, all staff receive training on high-risk activities and organisms that require enhanced barrier precaution. Review of Resident R35's Minimum Data Set (MDS-federal mandated resident assessment) dated January 2, 2025, revealed Resident R35 entered the facility on December 24, 2024 with a diagnosis of Type 2 diabetes (failure of the body to produce insuli). The resident was also assessed as having a diebetic foot ulcer.	F 0880		

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F 0880 SS=D	Continued from page 59 Review of resident's care plan revealed that this resident required assistant and was dependent for all ADL (activities of daily living) care in bathing, grooming ,personal hygiene, dressing, eating, bed mobility, and transfers related to paralysis and weakness affecting left side. Continued review of resident's care plan revealed this resident is at risk for skin breakdown related to an actual pressure ulcer. Review of resident's clinical record revealed a Kardex (document that provides instructions related to resident's care needs) included code status, activities, preferences, behavior, cognition, and toileting. Further review of the Kardex indicated to monitor for skin breakdown, dressing, grooming and skin care. This document had no indication that Resident R35 was on enhanced barrier precautions. Review of resident's wound care notes revealed resident has an arterial right dorsum first digit wound (right big toe).	F 0880		

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F 0880 SS=D	Continued from page 60 Observation of Employee E16 providing incontinence care to Resident R35 on February 9, 2025 at 11:00 a.m. revealed that Employee E16 was only wearing gloves,and no gown. Interview with Employee E 16 at time of observation, this employee denied that PPE was required for resident R 35, the enhanced barrier precaution sign on the door was indicated for resident R 35's roommate. The resident occupying the second bed in this room was also ordered enhanced barrier precautions. 28 pa. Code 211.12(d)(1)(5) Nursidneg Services 28 Pa. Code 201.14(a) Responsibility of licensee	F 0880		

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F 0880 SS=D	Continued from page 61	F 0880		
F 0947 SS=D		F 0947		

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F 0947 SS=D	Continued from page 62 483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	1. Employee E9 completed their 12 hours annual inservice education. 2.NPE or designee to conduct an initial audit of all CNA's to ensure 12 hour annual in-servicing is in compliance 3.NPE will be re-educated by the DON on the importance of ensuring all Nurse Aides completed at least 12 hours of inservice education annually. 4. NPE will conduct random monthly audits to ensure all Nurse Aides completed at least 12 hours of inservice education annually X 3 months. 5.DON or designee to review the results of these audits at the monthly QAPI meeting x 3 months.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

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F 0947 SS=D	Continued from page 63 Based on review of personnel records and interviews with staff it was determined that the facility failed to ensure that nurse aides received at least 12 hours of in-service education per year as required for one of six nurse aide personnel files reviewed (Employee E9). Findings include: Review of Employee E9's personnel file revealed that the employee was hired on June 20, 2019, as a nurse aide. Continued review revealed that from February 11, 2024, through February 10, 2025, Employee E9, nurse aide, completed only two courses of annual education: hand hygiene and personal protective equipment. Interview on February 10, 2025, at 12:52 p.m. the Nursing Home Administrator confirmed that Employee E9, nurse aide, had not completed 12 hours of annual in-service education as required. 28 Pa Code 201.19(7) Personnel policies and	F 0947		

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F 0947 SS=D	Continued from page 64 procedures 28 Pa Code 201.20(a) Staff development	F 0947		

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P 5510	Nursing services. (2) Effective July 1, 2023, a minimum of 1 nurse aide per 12 residents during the day, 1 nurse aide per 12 residents during the evening, and 1 nurse aide per 20 residents overnight. This REGULATION is not met as evidenced by:	P 5510	1. All residents received care in accordance with their plan of care and attending physician orders 2. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. The facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. 3.All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. 4. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. 5. Results will be taken to the QAPI for review and revision as needed.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5510	Continued from page 1 Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one nurse aide per 12 residents during the day shift, one nurse aide per 12 residents during the evening shift and one nurse aide per 20 residents during the overnight shift, for two of two days reviewed (June 29 and 30, 2024). Findings include: Review of facility census data revealed that on June 29, 2024, the facility census was 94, which required 58.75 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 43.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on June 30, 2024, the facility census was 93, which required 58.13 hours of nurse aides during the day shift.	P 5510		

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P 5510	Continued from page 2 Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on June 30, 2024, the facility census was 93, which required 58.13 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on February 11, 2024, at 2:00 p.m. The Nursing Home Administrator confirmed that the required staffing ratios for nurse aides were not met on the above dates.	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396009	A. BLDG: 00 B. WING:	02/11/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NORRITON SQUARE NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **068202**	**1700 PINE STREET NORRISTOWN, PA 19401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. All residents received care in accordance with their plan of care and attending physician orders 2. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. The facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. 3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. 4. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. 5. Results will be taken to the QAPI for review and revision as needed.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 4 Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one nurse aide per 10 residents during the day shift, one nurse aide per 11 residents during the evening shift and one nurse aide per 15 residents during the overnight shift, on 17 of 19 days reviewed (July 1, 2, 3, 4 and 5, 2024; September 28 and 29, 2024; October 1, 2, 3 and 4, 2024; February 3, 4, 5, 7, 8 and 9, 2025). Findings include: Review of facility census data revealed that on July 1, 2024, the facility census was 92, which required 69.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 60.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July	P 5520		

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P 5520	Continued from page 5 1, 2024, the facility census was 92, which required 62.73 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 42.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 1, 2024, the facility census was 92, which required 46.00 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 2, 2024, the facility census was 92, which required 69.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift. No additional excess	P 5520		

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P 5520	Continued from page 6	P 5520		

higher-level staff were available to compensate this deficiency.

Review of facility census data revealed that on July 2, 2024, the facility census was 92, which required 46.00 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency.

Review of facility census data revealed that on July 3, 2024, the facility census was 92, which required 69.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 60.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency.

Review of facility census data revealed that on July 3, 2024, the facility census was 92, which required

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P 5520	Continued from page 7 62.73 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 41.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 4, 2024, the facility census was 91, which required 62.05 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 5, 2024, the facility census was 91, which required 68.25 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 58.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this	P 5520		

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P 5520	Continued from page 8 deficiency. Review of facility census data revealed that on July 5, 2024, the facility census was 91, which required 45.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 22.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on September 28, 2024, the facility census was 88, which required 66.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 60.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on September 28, 2024, the facility census was 88, which required 44.00 hours of nurse aides during	P 5520		

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P 5520	Continued from page 9 the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on September 29, 2024, the facility census was 88, which required 66.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on September 29, 2024, the facility census was 88, which required 60.00 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 45.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 10 Review of facility census data revealed that on October 1, 2024, the facility census was 88, which required 66.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on October 2, 2024, the facility census was 88, which required 66.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on October 2, 2024, the facility census was 88, which required 60.00 hours of nurse aides during the evening shift. Review of the nursing time schedules	P 5520		

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P 5520	Continued from page 11 and punch reports revealed 52.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on October 2, 2024, the facility census was 88, which required 44.00 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on October 3, 2024, the facility census was 88, which required 66.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 52.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 12 Review of facility census data revealed that on October 3, 2024, the facility census was 88, which required 44.00 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on October 4, 2024, the facility census was 88, which required 66.00 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 58.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on October 4, 2024, the facility census was 88, which required 44.00 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 22.50 hours of nurse	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 13 aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 3, 2025, the facility census was 91, which required 45.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 4, 2025, the facility census was 91, which required 68.25 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 60.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on	P 5520		

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P 5520	Continued from page 14 February 5, 2025, the facility census was 93, which required 69.75 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 60.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 5, 2025, the facility census was 93, which required 46.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 7, 2025, the facility census was 94, which required 64.09 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 51.00 hours of nurse aide care was provided during the shift. No	P 5520		

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P 5520	Continued from page 15 additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 8, 2025, the facility census was 95, which required 71.25 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 67.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 8, 2025, the facility census was 95, which required 64.77 hours of nurse aides during the evening shift. Review of the nursing time schedules and punch reports revealed 51.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 8, 2025, the facility census was 95, which	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 16 required 47.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules and punch reports revealed 37.50 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 9, 2025, the facility census was 95, which required 71.25 hours of nurse aides during the day shift. Review of the nursing time schedules and punch reports revealed 45.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on February 11, 2024, at 2:00 p.m. The Nursing Home Administrator confirmed that the required staffing ratios for nurse aides were not met on the above dates.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1, All residents received care in accordance with their plan of care and attending physician orders 2.The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. The facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. 3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. 4. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. 5. Results will be taken to the QAPI for review and revision as needed.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 18 Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one LPN (Licensed Practical Nurse) per 25 residents during the day shift, one LPN per 30 residents during the evening shift, and one LPN per 40 residents during the overnight shift, on 6 of 21 days reviewed (June 29, 2024; July 2, 4 and 5, 2024; February 4 and 6, 2025). Findings include: Review of facility census data revealed that on June 29, 2024, the facility census was 94, which required 25.07 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 24.00 hours of LPN care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 2, 2024, the facility census was 92, which required	P 5530		

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	396009	A. BLDG: 00 B. WING:	02/11/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NORRITON SQUARE NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **068202**	**1700 PINE STREET NORRISTOWN, PA 19401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5530	Continued from page 19 24.53 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 24.00 hours of LPN care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 4, 2024, the facility census was 91, which required 24.27 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 24.00 hours of LPN care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 5, 2024, the facility census was 91, which required 24.27 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 16.00 hours of LPN care was provided during the shift. No additional excess higher-level staff were available to compensate this	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396009	A. BLDG: 00 B. WING:	02/11/2025

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P 5530	Continued from page 20 deficiency. Review of facility census data revealed that on February 4, 2025, the facility census was 91, which required 24.27 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 24.00 hours of LPN care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on February 6, 2025, the facility census was 93, which required 24.80 hours of LPNs during the evening shift. Review of the nursing time schedules and punch reports revealed 24.00 hours of LPN care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on February 11, 2024, at 2:00	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 21 p.m. The Nursing Home Administrator confirmed that the required staffing ratios for LPNs were not met on the above dates.	P 5530		
P 5630		P 5630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5630	Continued from page 22 Nursing services. (1) Effective July 1, 2023, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.87 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5630	1. All residents received care in accordance with their plan of care and attending physician orders 2.The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. The facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. 3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. 4. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396009	A. BLDG: __00_____ B. WING: _____	02/11/2025

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P 5630	Continued from page 23	P 5630	5.Results will be taken to the QAPI for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5630	Continued from page 24 Based on review of nursing time schedules, punch reports and staff interviews, it was determined that the facility failed to provide a minimum of 2.87 hours of direct nursing care per resident on two of two days reviewed (June 29 and 30, 2024). Findings include: Review of facility census data, punch reports and nursing time schedules revealed that on June 29, 2024, the facility census was 94, and a total of 237.50 direct nursing staff hours were provided, which equaled 2.53 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on June 30, 2024, the facility census was 93, and a total of 217.00 direct nursing staff hours were provided, which equaled 2.33 hours of direct nursing care per resident. Staffing calculations, nursing staff schedules and staff	P 5630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5630	Continued from page 25 punch reports were reviewed with the Nursing Home Administrator on February 11, 2024, at 2:00 p.m. The Nursing Home Administrator confirmed that the required staffing ratios for direct nursing care hours per resident were not met on the above dates.	P 5630		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 26 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1. All residents received care in accordance with their plan of care and attending physician orders 2. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. The facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. 3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. 4. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months.	Completion Date: **04/02/2025** Status: **APPROVED** Date: **03/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 27	P 5640	5. Results will be taken to the QAPI for review and revision as needed.	

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P 5640	Continued from page 28 Based on review of nursing time schedules, punch reports and staff interviews, it was determined that the facility failed to provide a minimum of 3.20 hours of direct nursing care per resident on 15 of 19 days reviewed (July 1, 2, 3, 4 and 5, 2024; September 28, 29 and 30, 2024; October 1, 2, 3 and 4, 2024; February 7, 8 and 9, 2025). Findings include: Review of facility census data, punch reports and nursing time schedules revealed that on July 1, 2024, the facility census was 92, and a total of 251.50 direct nursing staff hours were provided, which equaled 2.73 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on July 2, 2024, the facility census was 92, and a total of 260.00 direct nursing staff hours were provided, which equaled 2.83 hours of direct nursing care per resident.	P 5640		

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P 5640	Continued from page 29 Review of facility census data, punch reports and nursing time schedules revealed that on July 3, 2024, the facility census was 92, and a total of 289.50 direct nursing staff hours were provided, which equaled 3.15 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on July 4, 2024, the facility census was 91, and a total of 270.00 direct nursing staff hours were provided, which equaled 2.97 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on July 5, 2024, the facility census was 91, and a total of 241.00 direct nursing staff hours were provided, which equaled 2.65 hours of direct nursing care per resident. Review of facility census data, punch reports and	P 5640		

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P 5640	Continued from page 30 nursing time schedules revealed that on September 28, 2024, the facility census was 88, and a total of 262.00 direct nursing staff hours were provided, which equaled 2.98 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on September 29, 2024, the facility census was 88, and a total of 246.50 direct nursing staff hours were provided, which equaled 2.80 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on September 30, 2024, the facility census was 88, and a total of 267.50 direct nursing staff hours were provided, which equaled 3.04 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on October 1, 2024, the facility census was 88, and a total of	P 5640		

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P 5640	Continued from page 31 270.00 direct nursing staff hours were provided, which equaled 3.07 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on October 2, 2024, the facility census was 88, and a total of 254.50 direct nursing staff hours were provided, which equaled 2.89 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on October 3, 2024, the facility census was 88, and a total of 268.50 direct nursing staff hours were provided, which equaled 3.05 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on October 4, 2024, the facility census was 88, and a total of 251.00 direct nursing staff hours were provided, which equaled 2.85 hours of direct nursing care per	P 5640		

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P 5640	Continued from page 32 resident. Review of facility census data, punch reports and nursing time schedules revealed that on February 7, 2025, the facility census was 94, and a total of 298.50 direct nursing staff hours were provided, which equaled 3.18 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on February 8, 2025, the facility census was 95, and a total of 268.00 direct nursing staff hours were provided, which equaled 2.82 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on February 9, 2025, the facility census was 95, and a total of 282.00 direct nursing staff hours were provided, which equaled 2.97 hours of direct nursing care per resident.	P 5640		

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P 5640	Continued from page 33 Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on February 11, 2024, at 2:00 p.m. The Nursing Home Administrator confirmed that the required staffing ratios for direct nursing care hours per resident were not met on the above dates.	P 5640		

Certified End Page

NORRITON SQUARE NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 068202

SURVEY EXIT DATE: 02/11/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY